

No. 2
4-343
5-17-39
K36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23821**

FILED AUG 7 1947
Registration District No. **160**

Primary Registration District No. **5385**

Registrar's No. **19**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **DENT**

(b) City or town **RURAL - MERAMEE TWP.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **NONE**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **DENT**

(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")

(d) Street No. **NEAR SALEM, MO**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **BETTY LOU DUNLAP**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **50**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **AUG 1 1943**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
3	11	12	hr. 0 min.

9. Birthplace **DENT CO. MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **CHILD**

MOTHER FATHER

11. Industry or business _____

12. Name **LAWRENCE DUNLAP**

13. Birthplace **DILLARD MO**
(City, town, or county) (State or foreign country)

14. Maiden name **MUREL HEDRICK**

15. Birthplace **MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Julia Crutcher**

(b) Address **MIDDLEBROOK, MO**

17. (a) **BURIAL** (b) Date thereof **7-17-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **DILLARD, MO**

18. (a) Signature of funeral director **Earl H. Spencer**

(b) Address **SALEM, MO**

19. (a) **7-22-47** (b) **Wm. Hart, M.D.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **13**
year **1947** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him **Not seen alive** alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Burned to death

Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: **168**

Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **(Home)**

While at work? _____ (Specify type of place) (Means of injury)

23. Signature **M. M. Hart MD** (M.D. or other) **3/22**
Salem, MO Date signed **7/22/47**

RECEIVED

District

District

into filed

Officer No. 5

847427

8-5-47

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Wm W. McDonald

Licensed Embalmer No. 2806

P. O. Address Salem, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 100 Primary Registration District No. 5385

1. PLACE OF DEATH:
(a) County dent
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME Betty Lee Dunlap
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Aug 1 (Month) (Day) (Year)

8. AGE: Years 3 Months 1 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Specify type of place)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day 13 Year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy 168
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Homicide
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other)
Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

23821